HEALTH CARE OVERVIEW

Health Care Transparency and "No Surprises Act" Requirements

Group health plans and health insurance issuers are subject to many new requirements designed to increase health care transparency and protect consumers against surprise medical bills. These requirements come from final rules regarding transparency in coverage (TiC Final Rules), which were issued by the Departments of Labor, Health and Human Services and the Treasury (Departments) in November 2020, and the Consolidated Appropriations Act, 2021 (CAA), which was signed into law in December 2020.

The reforms broadly apply to group health plans (including fully insured plans, self-insured plans and level-funded plans) and health insurance issuers of individual and group coverage.

In general, most employers will rely on their issuers, third-party administrators (TPAs) and other service providers to satisfy many of the new requirements, including the obligations to provide machine-readable files (MRFs) and a cost comparison tool and submit detailed reports on prescription drug spending. Employers should confirm that their written agreements with their issuers, TPAs or other service providers are updated to address this compliance responsibility.

LINKS AND RESOURCES

- TiC Final Rules
- Departments' FAQ guidance from August 2021 addressing a number of CAA requirements
- Final rules on preventing surprise medical bills
- Interim final rules on prescription drug reporting

Key Reforms

Key reforms related to transparency and surprise medical bills include:

- MRFs with detailed price information
- Self-service cost comparison tool
- Reporting on prescription drug costs
- Prohibition on gag clauses
- Broker compensation disclosures
- Ban on balance billing
- Continuity of care requirements

Important Deadlines

The requirements have various effective dates. Some key deadlines are as follows:

- **Self-service cost comparison tool**—Plan years beginning on or after Jan. 1, 2023
- **Reporting on prescription drug costs**—Dec. 27, 2022 (submission grace period through Jan. 31, 2023)
- **Gag clause attestations**—Dec. 31, 2023

Summary of Compliance Requirements

TiC Final Rules

Requirement	Quick Summary	Effective Date
Public posting of MRFs	Health plans and issuers must disclose detailed pricing information in three MRFs on a public website. The following MRFs are required: • In-network provider negotiated rates for covered items and services (In-network Rate File); • Historical payments to and billed charges from out-of-network providers (Allowed Amount File); and • In-network negotiated rates and historical net prices for covered prescription drugs (Prescription Drug File).	Plan years beginning on or after **Jan. 1, 2022**. However, enforcement of the In-network Rate and Allowed Amount Files was delayed until **July 1, 2022**. Enforcement of the Prescription Drug File is delayed until further notice.
Self-service price comparison tool	Health plans and issuers must make an internet-based self-service tool available to participants, beneficiaries and enrollees to disclose the personalized price and cost-sharing liability for covered items and services, including prescription drugs. Upon request, plans and issuers must provide this information in paper form. To comply with the CAA's price comparison tool (described below), plans and issuers must also provide this comparison information over the telephone upon request.	For plan years beginning on or after **Jan. 1, 2023**, price comparison information must be available for 500 items and services identified in the TiC Final Rules. For plan years beginning on or after **Jan. 1, 2024**, price comparison information must be available for all covered items and services.

Consolidated Appropriations Act (CAA)

Requirement	Quick Summary	Effective Date
Reporting prescription drug costs	Health plans and issuers must report information about prescription drugs and health care spending to the Departments each year.	The report was initially required to be provided by Dec. 27, 2021, and by June 1 of each following year. However, the initial deadline was extended to **Dec. 27, 2022**. The Departments then provided a **submission grace period through Jan. 31, 2023**, if a good faith

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2022-2023 Zywave, Inc. All rights reserved.

Requirement	Quick Summary	Effective Date
		submission of 2020 and 2021 data is made by that date.
Prohibition on gag clauses	Health plans and issuers cannot enter into contracts with providers, TPAs or other service providers that would restrict the plan or issuer from providing, accessing or sharing certain information about provider price and quality and deidentified claims. Plans and issuers must annually submit an attestation of compliance with these requirements.	Dec. 27, 2020. The first attestation is due by Dec. 31, 2023, covering the period beginning Dec. 27, 2020, through the date of attestation. Subsequent attestations, covering the period since the last attestation, are due by Dec. 31 of each following year.
Broker and service provider compensation	Brokers and consultants must disclose any direct or indirect compensation they may receive for their services to ERISA-covered group health plan sponsors.	Contracts entered into, extended or renewed on or after Dec. 27, 2021.
Ban on balance billing	Health plans and issuers must provide protections against balance billing and out-of-network cost sharing with respect to emergency services, air ambulance services furnished by nonparticipating providers and nonemergency services furnished by nonparticipating providers at participating facilities. In addition, plans and issuers must publicly post a notice of these protections and include the notice with any explanation of benefits (EOB) for an item or service to which the protections apply.	Plan years beginning on or after Jan. 1, 2022.
Continuity of care	Health plans and issuers must provide continuity of care to qualifying covered individuals when terminations of certain contractual relationships result in changes in provider or facility network status.	Plan years beginning on or after Jan. 1, 2022.
Transparency in identification (ID) cards	Health plans and issuers must include on any physical or electronic ID card, any applicable deductibles and out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance.	Plan years beginning on or after Jan. 1, 2022.
Accuracy of provider	Health plans and issuers must maintain participating provider directories on a public website; regularly verify and update the directory information; and have a process in place for responding to requests for information about	Plan years beginning on or after Jan. 1, 2022.

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2022-2023 Zywave, Inc. All rights reserved.

Requirement	Quick Summary	Effective Date
directory information	participating providers. If inaccurate information is provided, a covered individual cannot be required to pay more than in-network cost sharing.	
Price comparison tool	Similar to the TiC Final Rules, the CAA requires health plans and issuers to provide an internet-based cost comparison tool for covered individuals. The Departments have indicated that they will likely view compliance with the TiC Final Rules' comparison tool to satisfy the CAA's price comparison tool requirement. However, the CAA also requires plans and issuers to provide cost comparison information over the telephone upon request, which is an additional requirement that plans and issuers must comply with beginning in 2023.	Plan years beginning on or after Jan. 1, 2023.
Advanced EOBs	Health plans and issuers must provide an advanced EOB to covered individuals after receiving a good faith estimate of charges from a health care provider or facility.	Delayed until further notice.

Transparency Requirements: TiC Final Rules

The TiC Final Rules require group health plans and health insurance issuers to make certain price information accessible to consumers and other stakeholders, allowing for easy comparison shopping. Health plans and issuers must publicly post certain MRFs with detailed cost information and provide an internet-based cost comparison tool for participants, beneficiaries and enrollees.

These requirements apply to group health plans, including self-insured plans and level-funded plans, and health insurance issuers of individual and group coverage. Grandfathered health plans, excepted benefits (for example, limited-scope dental and vision benefits) and account-based group health plans, such as health reimbursement arrangements (HRAs) and health flexible spending accounts (FSAs), are NOT subject to these transparency disclosures.

Employer Compliance Steps

Most employers will rely on their health insurance issuers and TPAs (or other service providers) to provide the MRFs and cost comparison tool. Employers with fully insured health plans should confirm that their issuer will comply with the TiC Final Rules' transparency requirements by the applicable deadlines and ensure this compliance responsibility is set forth in a written agreement. Similarly, employers with self-insured plans should reach out to their TPAs (or other service providers) to confirm they will be in compliance by the applicable deadlines and update agreements, as necessary, to reflect this responsibility.

MRFs

Health plans and health insurance issuers must disclose, on a public website, **detailed pricing information in three separate MRFs**. Specifically, the following information must be disclosed:

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2022-2023 Zywave, Inc. All rights reserved.

- In-network provider negotiated rates for covered items and services (In-network Rate File);
- Historical payments to and billed charges from out-of-network providers (Allowed Amount File); and
- In-network negotiated rates and historical net prices for covered prescription drugs (the Prescription Drug File).

The files must be publicly available and accessible free of charge without any restrictions. Plans and issuers must update the information required to be included in each MRF on a monthly basis to ensure it remains accurate, and they must clearly indicate the date the files were most recently updated.

In the TiC Final Rules, the Departments acknowledge that these MRFs will likely be very large and difficult for health care consumers to navigate. However, according to the Departments, the main purpose of making this pricing information publicly available is to allow third-party, internet-based developers to innovate, resulting in new consumer-facing tools.

These MRFs are required to be made public for plan years that begin on or after Jan. 1, 2022. However, in a series of FAQs from August 2021, the Departments delayed the enforcement of the requirement to publicly post the In-network Rate and Allowed Amount Files until July 1, 2022. This means, for example, that calendar year health plans must comply with this disclosure requirement as of July 1, 2022. However, for 2022 plan years beginning after July 1, 2022, MRFs must be posted by the month in which the plan year begins (for example, Sept. 1, 2022, for a plan year from Sept. 1 to Aug. 31). Enforcement of the Prescription Drug File is delayed until further notice from the Departments.

Price Comparison Tool

The TiC Final Rules require group health plans and health insurance issuers to make an **internet-based self-service tool** available to participants, beneficiaries and enrollees to disclose the personalized price and cost-sharing liability for all covered health care items and services, including prescription drugs. This tool must be available without a subscription or other fee. Also, upon request, group health plans and issuers must make this information available in paper form. To comply with the CAA's price comparison tool requirement (see below), plans and issuers should also be prepared to provide this comparison information over the telephone upon request.

This price comparison tool must be available by the following phased-in deadlines:

- **For plan years beginning on or after Jan. 1, 2023**, plans and issuers must make price comparison information available for 500 shoppable items, services and drugs identified by the Departments in the TiC Final Rules.
- **For plan years beginning on or after Jan. 1, 2024**, plans and issuers must make price comparison information available for all covered items, services and drugs.

Interaction with CAA's price comparison tool

Similar to the TiC Final Rules, the CAA requires plans and issuers to make a "price comparison tool" available on the plan's or issuer's website. The CAA also requires plans and issuers to provide price comparison guidance by telephone, upon request, to individuals enrolled in coverage. According to a series of FAQs, the Departments intend to issue proposed rules addressing whether compliance with the TiC Final Rules' price comparison tool satisfies the CAA's price comparison requirements. The Departments intend to propose that the same pricing information available through the online tool or in paper form also be provided over the telephone upon request. The CAA's price comparison requirement is effective for plan years beginning on or after Jan. 1, 2022. However, to coincide with the TiC Final Rules, the Departments will not enforce the requirement that a plan or issuer makes available a price comparison tool (by internet website, in paper form or telephone) for plan years beginning before Jan. 1, 2023.

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2022-2023 Zywave, Inc. All rights reserved.

CAA Transparency Provisions/No Surprises Act

The CAA includes a number of different requirements for group health plans and health insurance issuers to increase health care transparency and protect consumers from surprise medical bills. These requirements have varying effective dates.

In general, these CAA requirements apply to group health plans, including self-insured plans and level-funded plans, and health insurance issuers of individual and group coverage. Excepted benefits (for example, limited-scope dental and vision benefits) and account-based group health plans (such as HRAs and health FSAs) are NOT subject to these requirements.

Employer Compliance Steps

Most employers will rely on their health insurance issuers and TPAs (or other service providers) to satisfy the CAA's requirements for transparency and surprise medical bills. Employers should confirm that their carriers and TPAs are complying with CAA requirements that have taken effect, such as the ban on balance billing, ID card transparency and accuracy of provider directory information.

In addition, most employers will rely on their carriers, TPAs or other third parties to report prescription drug costs by Jan. 31, 2023 (and by June 1 of each following year). According to the Departments' interim final rules, employers that rely on their carriers and TPAs (or other service providers) should update their written agreements with these parties to reflect that responsibility. Thus, employers should reach out to their carriers and TPAs (or other service providers) to confirm they will timely submit the prescription drug reports and update written agreements, as necessary, to reflect this responsibility.

Similarly, employers may use their issuers and TPAs to provide gag clause attestations by Dec. 31 of each year, beginning Dec. 31, 2023. According to FAQs issued by the Departments, when the issuer of a fully insured group health plan submits a gag clause compliance attestation on behalf of the plan, the Departments will consider the plan and issuer to have satisfied the attestation submission requirement. Employers with self-insured health plans can satisfy the gag clause compliance attestation requirement by entering into a written agreement under which the plan's service provider, such as a TPA, will provide the attestation on the plan's behalf. However, even if this type of agreement is in place, the legal requirement to provide a timely attestation remains with the health plan.

Reporting Prescription Drug Costs (Transparency)

The CAA requires group health plans and health insurance issuers to report information about prescription drugs and health care spending to the Departments. Specifically, plans and issuers must report the following:

- The beginning and end dates of the plan year;
- The number of enrollees;
- Each state in which the plan is offered;
- The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan and the total number of paid claims for each drug;
- The 50 most costly prescription drugs with respect to the plan by total annual spending and the annual amount spent by the plan for each drug;
- The 50 prescription drugs with the greatest increase in plan expenditures over the prior plan year, and for each drug, the change in amounts expended by the plan in each plan year;

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2022-2023 Zywave, Inc. All rights reserved.

- Total spending on health care services by the group health plan, broken down by the type of costs, the average monthly premium paid by employers (as applicable) and enrollees, and any impact on premiums by rebates, fees and any other remuneration paid by drug manufacturers to the plan; and
- Any reduction in premiums and out-of-pocket costs associated with rebates, fees or other remuneration.

The Department of Health and Human Services (HHS) has released instructions for submitting this information, which it calls the Prescription Drug Data Collection (RxDC report).

The report was initially required to be submitted by Dec. 27, 2021, and by June 1 of each year thereafter. However, in interim final rules, the Departments deferred enforcement of these deadlines, stating that they will not initiate enforcement action against a plan or issuer that submits the required information by Dec. 27, 2022. The Departments then provided a **submission grace period through Jan. 31, 2023**, so long as plans and issuers make a good faith submission of 2020 and 2021 data on or before that date.

To facilitate the submission process, the Departments also provided certain clarifications and flexibilities with respect to reporting requirements for 2020 and 2021 data (e.g., allowing multiple submissions by the same reporting entity, email submission of certain data for certain plans, and optional reporting for certain data), which are outlined in an FAQ.

Prohibition on Gag Clauses (Transparency)

To allow for health care transparency, the CAA prohibits health plans and issuers from entering into an agreement with a provider, network of providers, TPA or other service provider offering access to a network of providers that would restrict the plan or issuer from:

1. Providing provider-specific cost or quality-of-care information or data to referring providers, the plan sponsor, participants, beneficiaries or enrollees (or individuals eligible to become participants, beneficiaries or enrollees of the plan or coverage);
2. Electronically accessing de-identified claims and encounter information or data for each participant, beneficiary or enrollee upon request and consistent with privacy rules under the Health Insurance Portability and Accountability Act (HIPAA), the Genetic Information Nondiscrimination Act (GINA), and the Americans with Disabilities Act (ADA); and
3. Sharing information or data described in (1) and (2) above or directing such information to be shared with a business associate, consistent with applicable privacy rules.

For example, if a contract between a TPA and a health plan provides that the plan sponsor's access to provider-specific cost and quality-of-care information is only at the discretion of the TPA, that contractual provision would be considered a prohibited gag clause.

The CAA's prohibition on gag clauses became effective **Dec. 27, 2020**. In addition, plans and issuers must annually submit to the Departments an **attestation of compliance** with these requirements. On Feb. 23, 2023, the Departments issued FAQs on the gag clause prohibition. These FAQs require health plans and issuers to submit their first attestation of compliance with the prohibition of gag clauses by **Dec. 31, 2023**. Subsequent attestations, covering the period since the last attestation, are due by Dec. 31 of each following year.

The Departments launched a website through the Centers for Medicare and Medicaid Services for health plans and issuers to submit their gag clause compliance attestations. The Departments have also provided instructions for submitting the

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2022-2023 Zywave, Inc. All rights reserved.

attestation, a system user manual, and a reporting entity Excel template for plans and issuers to submit the required attestation, all of which are available here.

Disclosure of Broker Compensation (Transparency)

The CAA creates new requirements for brokers and consultants to disclose to ERISA-covered group health plan sponsors any **direct or indirect compensation** they receive for their services. These new disclosure requirements generally apply to contracts entered into, extended or renewed on or after **Dec. 27, 2021**.

ERISA requires plan fiduciaries to, among other things, ensure that arrangements with their plan service providers are "reasonable" and that only "reasonable" compensation is paid for services. To meet these obligations, the CAA requires covered service providers (CSPs) to provide health plan fiduciaries (for example, plan sponsors) with the information they need to assess the reasonableness of total compensation, both direct and indirect, received by the CSP, its affiliates and/or its subcontractors.

For this purpose, the term "covered service provider" means one that enters into a contract with the plan and reasonably expects **$1,000 or more in compensation** (direct or indirect) to be received in connection with providing one or more of the services listed below—regardless of whether the services will be performed or compensation will be received by the CSP, an affiliate or a subcontractor. Specifically, disclosure is required for:

- **Brokerage services** provided to a covered plan with respect to the selection of insurance products (including vision and dental), record-keeping services, medical management vendors, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs or third-party administration services;
- **Consulting services** related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), record-keeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs or third-party administration services.

Disclosure must be made no later than the date that is **reasonably in advance of the date on which the contract is entered into. extended or renewed**. If the CSP fails to provide the required information above, the plan fiduciary may be required to notify the Department of Labor (DOL) and terminate the contract. According to a DOL Field Assistance Bulletin, a CSP will not be treated as having failed to make required disclosures to a responsible plan fiduciary **as long as the disclosures were made in accordance with a good faith, reasonable interpretation of the law**.

Ban on Balance Billing (No Surprises Act)

The No Surprises Act was enacted as part of the CAA to protect health care consumers from surprise medical bills in situations where they frequently occur. A surprise medical bill is an unexpected "balance bill" from a health care provider or facility that occurs when a covered person receives medical services from a provider or facility that, usually unknown to the covered person, is a nonparticipating provider or facility with respect to the individual's coverage. Balance billing occurs when out-of-network providers bill patients for the difference between (1) the provider's billed charges and (2) the

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2022-2023 Zywave, Inc. All rights reserved.

amount collected from the plan or issuer plus the amount collected from the patient in the form of cost sharing (such as a copayment or deductible amount).

Some states have enacted laws to reduce or eliminate balance billing, but these protections do not extend across all the states. Also, state law protections typically apply only to individuals enrolled in health insurance coverage—they do not usually apply to self-funded group health plans due to ERISA's broad preemption clause.

Effective for plan years beginning on or after Jan. 1, 2022, the CAA creates new federal protections against surprise billing and limits out-of-network cost sharing in certain situations. With respect to **emergency services**, **air ambulance services** furnished by nonparticipating providers and **nonemergency services furnished by nonparticipating providers at participating facilities**, the new law:

- Limits cost sharing for out-of-network services to in-network levels;
- Requires the cost sharing to count toward any in-network deductibles and out-of-pocket maximums; and
- Prohibits balance billing.

The CAA establishes an independent dispute resolution (IDR) process that allows plans and issuers and non-participating providers and emergency facilities to resolve disputes over out-of-network rates.

In addition, plans and issuers must make a **notice regarding the CAA's (and any applicable state law's) prohibitions on balance billing** publicly available, posting it on a public website of the plan or issuer and including it on each EOB for an item or service to which the CAA's protections apply. The Departments issued a model notice that plans and issuers may use (but are not required to use) to meet these disclosure requirements related to surprise billing.

Impact on ACA Patient Protections: The Affordable Care Act (ACA) established patient protections for group health plans and health insurance issuers, effective for plan years beginning on or after Sept. 23, 2010. The ACA's patient protections relate to the choice of a health care professional and benefits for emergency services. Under the ACA, grandfathered plans were not subject to these patient protections. Effective for plan years beginning on or after Jan. 1, 2022, the CAA expands the ACA's patient protections by removing the exception for grandfathered plans and expanding the required benefits for emergency services to prevent surprise medical bills.

Continuity of Care (No Surprises Act)

The CAA establishes continuity of care protections that apply in certain cases when a provider ceases to be an in-network provider during an ongoing course of treatment. If a covered individual is a "continuing care patient" with respect to an in-network provider or facility, the plan must provide notice to the individual and potentially provide transitional care for up to 90 days if:

- The contractual relationship between the plan and provider or facility is terminated;
- Plan benefits are terminated because of a change in the terms of the participation of the provider or facility in the plan; or
- A contract between the plan and its health insurance issuer is terminated, resulting in a loss of benefits provided under the plan with respect to the provider or facility.

If any of these events occur, plans and issuers must notify continuing care patients about their right to elect transitional care from the provider or facility.

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2022-2023 Zywave, Inc. All rights reserved.

These requirements are effective for **plan years beginning on or after Jan. 1, 2022**. Until the Departments issue regulations on the CAA's continuity of care requirement, plans and issuers are expected to implement it using a **good faith, reasonable interpretation of the law.**

Transparency in ID Cards (No Surprises Act)

The CAA requires health plans and issuers to include in clear writing, on any physical or electronic ID card issued to participants, beneficiaries or enrollees, any **applicable deductibles**, any **applicable out-of-pocket maximum limitations**, and a **telephone number and website address** for individuals to seek consumer assistance. These provisions apply with respect to **plan years beginning on or after Jan. 1, 2022**.

According to a series of FAQs, plans and issuers are expected to implement the ID card requirements using a **good faith, reasonable interpretation of the law** until the Departments issue further guidance to address implementation requirements, including how plans and issuers that offer complex plan and coverage designs should represent information on an ID card.

Accuracy of Provider Directory Information (No Surprises Act)

Effective for **plan years beginning on or after Jan. 1, 2022**, the CAA includes standards for provider directories that are intended to protect health care consumers against surprise medical bills. Health plans and issuers must:

- Maintain a directory on a public website that includes information on participating providers and facilities;
- Regularly verify and update the accuracy of this provider information (at least every 90 days); and
- Have a protocol in place for responding to covered individuals' requests by telephone, internet or other electronic means about a provider's network participation status.

Also, if a participant, beneficiary or enrollee receives inaccurate information (through the required provider directory or response protocol) and mistakenly receives care from an out-of-network provider or facility, the individual cannot be required to pay more than the in-network cost-sharing amount, and the plan or issuer must count cost-sharing amounts toward any in-network deductible or out-of-pocket maximum. Until the Departments issue regulations on the CAA's provider directory requirements, plans and issuers are expected to implement it using a **good faith, reasonable interpretation of the law.**

Advanced EOBs (No Surprises Act)

To help avoid surprise medical bills, the CAA requires health plans and issuers, upon receiving a "good faith estimate" (see below) from a provider or facility, to send the participant, beneficiary or enrollee an advanced EOB notification in clear and understandable language. The EOB may be sent by mail or electronic means, as requested by the covered individual.

Good Faith Estimates

Under the CAA, when a plan participant, beneficiary or enrollee schedules an item or service with a health care provider or facility, the provider or facility must provide a "good faith estimate" of the expected charges to the covered individual's health plan or health insurance coverage. The requirement to provide good faith estimates was originally effective for plan years beginning on or after Jan. 1, 2022. However, the Departments have recognized (in FAQ guidance) the complexities involved with developing the technical infrastructure to transmit these estimates from providers and facilities to plans and issuers. Accordingly, the enforcement of this requirement is delayed until the Departments issue rules to implement it.

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2022-2023 Zywave, Inc. All rights reserved.

The advanced EOB must include the following information:

- The network status of the provider or facility;
- The contracted rate for the item or service, or if the provider or facility is not a participating provider or facility, a description of how the individual can obtain information on providers and facilities that are participating;
- The good faith estimate received from the provider;
- A good faith estimate of the amount the plan or coverage is responsible for paying, and the amount of any cost sharing for which the individual would be responsible for paying with respect to the good faith estimate received from the provider; and
- Disclaimers indicating whether coverage is subject to any medical management techniques.

The notice also must indicate that the information provided is only an estimate and is subject to change. The timing for providing the advanced EOB depends on when the patient schedules the service or requests the estimate.

The advanced EOB requirement was originally effective for plan years beginning on or after Jan. 1, 2022. However, as noted above, the Departments have indefinitely delayed the requirement for providers to provide the good faith estimates, which are needed to prepare the advanced EOBs. Thus, the Departments have also **delayed the requirement for plans and issuers to provide advanced EOBs until the Departments issue rules to implement it**.

Price Comparison Tool (No Surprises Act)

Similar to the TiC Final Rules, the CAA requires plans and issuers to make a "price comparison tool" available on the plan's or issuer's website. The CAA also requires plans and issuers to provide price comparison guidance by telephone, upon request, to covered individuals. According to a series of FAQs, the Departments intend to issue proposed rules addressing whether compliance with the TiC Final Rules' price comparison tool satisfies the CAA's price comparison tool requirements. The CAA adds a requirement that was not imposed under the TiC Final Rules: Price information must be provided over the telephone upon request. The Departments intend to propose that the same pricing information available through the online tool or in paper form must also be provided over the telephone upon request.

The CAA's price comparison requirement was originally effective for plan years beginning on or after Jan. 1, 2022. However, in the FAQs, the Departments recognize that the price comparison methods required by the CAA are largely duplicative of the price comparison tool required by the TiC Final Rules and that plans and issuers have been expecting to implement the first phase (500 items and services) for plan years beginning on or after Jan. 1, 2023. **Accordingly, for plan years beginning before Jan. 1, 2023, the Departments will not enforce the requirement that a plan or issuer makes available a price comparison tool (by internet website, in paper form or by telephone).**

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. ©2022-2023 Zywave, Inc. All rights reserved.